UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

DITROPAN XL(oxybutynin chloride) **DETROL LA**(tolterodine tartrate) **ENABLEX**(darifenacin chloride) **SANCTURA**(trospium chloride)**VESICARE**(solifenacin succinate)
OXYTROL PATCH(oxybutynin)

Patient name:_____Medicaid or SS#_____

Physician Name:_____ Contact person:_____

Phone#:_____Ext. and options_____Fax#_____

Pharmacy_____Pharmacy Phone#:_____

Medication being requested_____

All information to be legible, complete and correct or form will be returned

_____

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FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

- **DOCUMENTED** failure on short acting oral formulations of oxybutynin for 45 days within the past 12 months

AUTHORIZATION:

1 year

RE-AUTHORIZATION:

Telephone request from physician' s office or pharmacy

1 year